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One-to-one relationship in high-risk prenatal care: a case study

Relação pessoa-a-pessoa no pré-natal de alto risco: um estudo de caso

Relación persona a persona en el cuidado prenatal de alto riesgo: un estudio de caso

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ABSTRACT

Objective: To analyze the one-to-one relationship in the context of home visits by nurses to high-risk pregnant women.

Method: A case study focused on the relationship established between the nurse and the pregnant woman during home visits. A total of 17 high-risk pregnant women participated, each receiving biweekly visits from nurses for a total of six to 10 visits throughout the prenatal period and into the first month postpartum. Evidence sources included audio recordings and field notes of the visits. The analysis was guided by Joyce Travelbee's theory which defines five phases for an interpersonal relationship, including original encounter, emerging identities, empathy, sympathy and rapport, necessary to achieve therapeutic interaction in care.

Results: The development of the one-to-one relationship allowed nurses to understand the individual needs of the pregnant women. Based on an understanding of each woman's uniqueness and determining factors, the nurse developed a personalized care plan in collaboration with the patient. Through this relationship, each party revealed themselves, leading to increased autonomy of the woman, who took the lead in achieving her projects, supported by the framework created by the nurse.

Final considerations: The one-to-one relationship during home visits produced practical outcomes by identifying specific needs through a therapeutic and collaborative interaction.

Descriptors: Prenatal care; High-risk pregnancy; Home visit; Interpersonal relationships; Case study.

RESUMO

Objetivo: Analisar a relação pessoa-a-pessoa no contexto de visitas domiciliares feitas por enfermeiras a gestantes de alto risco.

Método: Estudo de caso, focado na relação estabelecida entre enfermeira e gestante durante a visita domiciliar. Participaram 17 gestantes de alto risco, que foram visitadas quinzenalmente por enfermeiras, de seis a 10 vezes ao longo do pré-natal e até o primeiro mês após o parto. As fontes de evidência analisadas foram audiogravações e notas de campo das visitas. A análise foi orientada pela teoria de Joyce Travelbee que define cinco fases para uma relação interpessoal, sendo encontro inicial, identidades emergentes, empatia, simpatia e rapport, necessárias para o alcance da interação terapêutica no cuidado.

Resultados: O desenvolvimento da relação pessoa-a-pessoa permitiu que as necessidades individuais das gestantes fossem compreendidas pelas enfermeiras. Com base no entendimento da singularidade e dos fatores determinantes de cada mulher, a enfermeira, em colaboração com a gestante, desenvolveu um plano de cuidado personalizado. A partir dessa relação, cada parte se revelou, resultando na ampliação da autonomia da mulher, que assumiu o protagonismo na realização de seus projetos, sob o suporte criado pela enfermeira.

Considerações finais: A relação pessoa-a-pessoa nas visitas domiciliares gerou resultados práticos ao revelar necessidades particulares, por meio de uma interação terapêutica e colaborativa.

Descritores: Cuidado pré-natal; Gravidez de alto risco; Visita domiciliar; Relações interpessoais; Estudo de caso.

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RESUMEN

Objetivo: Analizar la relación persona a persona en el contexto de las visitas domiciliarias de enfermeras a gestantes de alto riesgo.

Método: Estudio de caso, tomando como caso la relación establecida entre una enfermera y una mujer embarazada durante una visita domiciliaria. Participaron 17 mujeres, las embarazadas de alto riesgo fueron visitadas cada quince días por enfermeras, de seis a 10 veces durante todo el control prenatal y hasta el primer mes después del parto. Las evidencias analizadas fueron grabaciones de audio y notas de campo. Análisis se basó en la teoría de Joyce Travelbee que define cinco fases de una relación interpersonal, incluyendo el encuentro inicial, las identidades emergentes, la empatía, la simpatía y rapport, necesarias para lograr la interacción terapéutica en el cuidado.

Resultados: A partir del desarrollo de la relación persona a persona, las necesidades particulares de la mujer fueron expuestas al enfermero, quien, con la comprensión de la singularidad y los determinantes, creó, colaborativamente con la mujer, el cuidado. Para eso, cada persona se reveló en la relación y, a partir de ahí, la autonomía de la mujer fue ampliada y asumida en la búsqueda de su(s) proyecto(s), bajo el cuidado solidario creado por la enfermera.

Consideraciones finales: La relación persona a persona en las visitas domiciliarias determinó éxitos prácticos al resaltar necesidades particulares a través de una interacción terapéutica colaborativa.

Descriptores: Cuidado prenatal; Embarazo de alto riesgo; Visita domiciliaria; Relaciones interpersonales; Estudio de caso.

INTRODUCTION

Healthcare has been predominantly developed under the biomedical paradigm, in which relationships are weakened and the appropriation of bodies and lives aims at control, devaluing social interactions[1,2]. In this context, care is often limited to the execution of healthcare protocols, without considering the particularities of the people who need health care[2].

This tendency of valuing the technical dimension of health care, at the expense of relationships between professionals, is also present in nursing, where the idea that care is restricted to technical procedures is normalized[3]. Care manifests at different moments of human development, but in "high-risk" situations, such as in High-Risk Prenatal Care (HRPC), the tension of technocentric interventions becomes more evident.

However, in the follow-up of pregnant women in HRPC, nursing practices are generally restricted to physical-obstetric factors, without considering other important aspects[4]. This leads to referrals and early ruptures of bonds, contributing to women's journey in search of care[5]. Although nurses recognize the psychosocial and emotional needs of these pregnant women, they rarely intervene in this area[4]. However, it is known that pregnant women value prenatal competencies linked to a holistic approach and sensitive listening[6].

Considering the particular needs of pregnant women classified as high-risk is a challenge, especially due to the need to access more complex resources and services[4], in addition to the difficulties that nurses face in providing coordinated and quality care during prenatal care[7].

Interactions between pregnant women and nurses during home visits promote the redefinition of the gestational experience and the reception of singularities. Pregnant women also highlight the efforts of nurses to coordinate the different services in the healthcare network[8]. In this sense, home visits (HV) are an effective tool for promoting dialogic relationships and addressing needs[8,9], contributing to equity and better perinatal outcomes[10,11].

Therefore, this study assumes that the relationship between the nurse and the person requiring their care is a strategic device for renewing attention in the context of the HRPC, especially in home visits. The objective of this research was to analyze the one-to-one relationship in the context of home visits by nurses to high-risk pregnant women.

METHOD

This is an exploratory study with a qualitative approach, based on the case study method[12] grounded in the one-to-one relationship theory proposed by Joyce Travelbee[13]. The case study is a methodological approach that seeks to understand a contemporary phenomenon based on reality. The aim is to understand the characteristics of everyday events from a holistic and meaningful perspective for knowledge, as nuances that are often invisible to the naked eye can be revealed through this strategy[12].

The study was developed between March 2018 and May 2021, in a medium-sized city in the interior of the state of São Paulo. At the time, the municipality offered prenatal and postpartum care for women at low risk in 12 basic health units (BHU) and 21 family

health units (FHU)[14]. Care at the HRPC was provided by a specialized outpatient clinic, in collaboration with Primary Health Care (PHC). Pregnant women classified as having obstetric risk were identified in the FHUs and BHUs and then referred to the high-risk pregnancy clinic by the responsible physician thus beginning their follow-up in the HRPC.

The inclusion criteria for this study were: being 18 years of age or older or, in the case of adolescents, being emancipated and being a high-risk pregnant woman followed up at the high-risk pregnancy outpatient clinic. Women who had conditions that interfered with their ability to engage in visits, such as severe mental disorders and/or cognitive deficits that hindered involvement in relationships were excluded.

The participants who agreed to participate in the study received HVs conducted by two nurses, structured based on Joyce Travelbee's one-to-one relationship theory[13]. For Travelbee, interpersonal relationships are central to nursing care, and authentic interaction is essential for revealing needs and developing care[13]. It is in the genuine encounter with the pregnant woman that the nurse creates a welcoming environment, where care is constructed through interaction between both parties[15].

Travelbee defines five phases of the interpersonal relationship to achieve therapeutic interaction[13]. These phases structured the visitation process, and the nurses were guided through the following steps: 1) Original encounter: the first contact between the nurse and the person receiving. In this encounter, the nurse strives to obtain information about the person, with the objective of establishing an initial relationship; 2) Phase of emerging identities: the nurse and the person being cared for create a relational space, in which they share information about themselves to get to know each other better and establish mutual commitment. This phase is overcome when both parties recognize and accept each other as unique individuals, with their capabilities and limitations; 3) Empathy: includes the interaction between the professional and the person being cared for, which occurs in a receptive environment, with comprehensive efforts to offer support and assistance; 4) Sympathy: trust becomes the pillar of the relationship, allowing the joint definition of realistic, and specific goals adapted to individual needs, directing the pursuit of established objectives; 5) Rapport: the parties review the relationship established in the previous phases and the results achieved. At this stage, a continuous evaluation of the relational dynamics occurs, based on the experience lived throughout the one-to-one relationship process.

The one-to-one relationship in this study was analyzed based on the HVs structured according to the phases of Travelbee's theory[13], conducted with high-risk pregnant women. Each visit focused on a specific phase, depending on the stage of the relationship established between the visiting nurses and the pregnant women. To report and analyze the case (the relationship), the sources of evidence included the full transcripts of the audio recordings and the nurses' field notes taken during the HVs.

The invitation to participate in the study was made by the nurses at the specialized high-risk pregnancy outpatient clinic to all pregnant women who started the follow-up at the facility and met the study criteria. If the woman agreed, the research nurses contacted her to explain the study proposal. Once the woman confirmed her interest, the first home visit was scheduled. A total of 34 women were invited, and 17 agreed to participate. The refusals were related to their unavailability to receive the visits.

The visiting professionals were two nurses, both cisgender and heterosexual women. All visits were audio-recorded and fully transcribed. Field notes were recorded and included in a diary immediately after each visit.

The empirical material was analyzed based on the one-to-one relationship theory[13], and the results were presented according to the phases of this framework, to facilitate understanding of the relationship's development . The first analysis procedure, "moment A", consisted of repeated readings of the transcribed material of each participating woman, focusing on the relational process and its impacts on care. In a second analytical moment, still in "moment A", new readings were performed, and relevant excerpts for the relational process were highlighted. From this, each case (the relationship with each pregnant woman) was analyzed, to understand the "how" and "why" that structured the relationship, either promoting or hindering care progress. After this process, the final stage was the writing

of a text integrating each relational process, according to the phases proposed by Travelbee[15] for the one-to-one relationship. The second analytical moment, "moment B", was the discussion of the results based on the scientific literature, following an inductive-deductive analysis process.

The study was approved by the Research Ethics Committee, according to Opinion No. 2,467,733, complied with Resolutions No. 466/2012 and 510/2016 of the National Health Council. All participants signed the Informed Consent Form after agreeing to participate in the study. To ensure anonymity, the pregnant women were identified by the initial "P", followed by a number (P1, P2, etc.).

RESULTS

The study participants were 17 women, who received between six and 10 visits throughout the prenatal period and up to the first month postpartum. A total of 132 HVs were carried out, guided by the phases of Travelbee's one-to-one relationships theory[13].

Regarding sociodemographic data, the average age of the pregnant women was 32 years, ranging from 20 to 44 years. The diagnoses that led to the classification of high-risk pregnancies included, mainly, hypertensive pregnancy syndromes, multiple pregnancies and gestational diabetes mellitus, with the first condition being the most prevalent.

The gestational age at the beginning of the HVs ranged from 14 to 37 weeks. All pregnant women were in a relationship with the child's father and were housewives. Regarding religious affiliation, 13 of the women had some religious affiliation, with variations between Catholicism, Evangelical Christianity, and Spiritism.

The results are organized according to the phases of the one-to-one relationship, highlighting the circular and dynamic movement that this relationship assumes throughout the interactions between the nurses and the pregnant women who experienced the HRPC. It is worth mentioning that the arrangement of the phases in a counterclockwise direction was intentional, aiming to encourage reflection during reading (Figure 1).

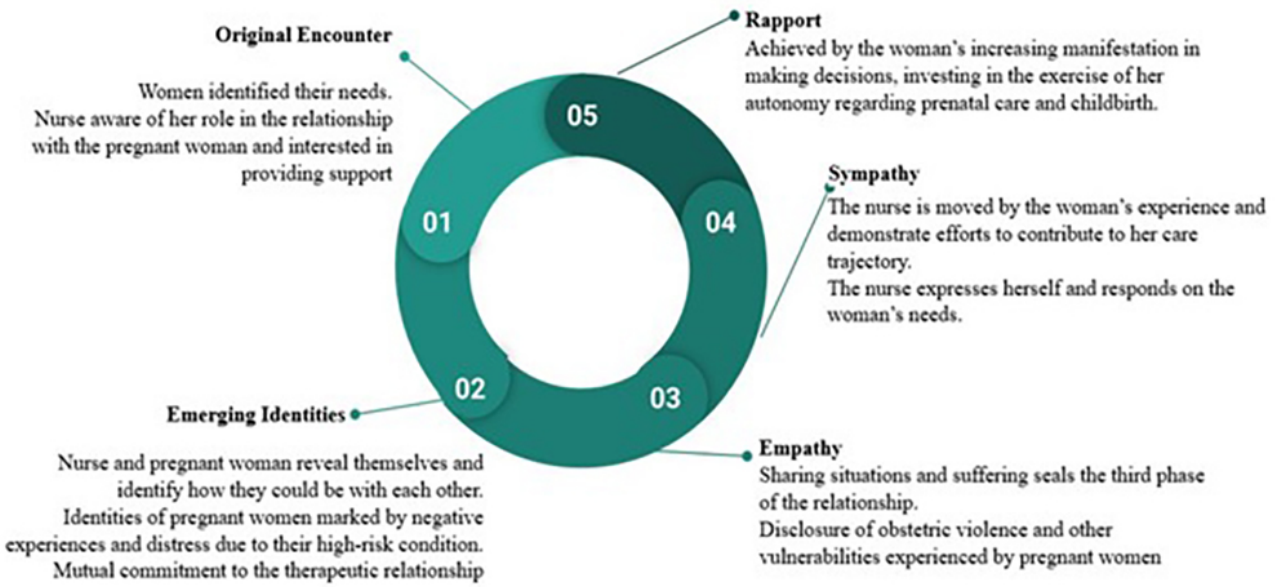

Figure 1 - Illustration of the phases of Travelbee's interpersonal relationship, focusing on the creation of a therapeutic interaction in the context of the HRPC.
Source: The authors, 2024.

Original Encounter

At this moment, the nurse sought to learn about the woman based on her own presentation, a process that generated initial impressions and influenced openness to the relationship, essential elements for building relational engagement. In the context of this study, it was clear that the women already expressed some of their needs in this first meeting. The need to be closely and continuously accompanied by a professional was verbalized by the participants, as stated in the following record:

> *G1, immediately after accepting the invitation, verbalized that someone close, a healthcare professional close to her, was what she most wanted and needed.* (Field note 14)

In the initial encounters, the nurse, aware of the relationship she intended to build with the pregnant women, reflected on how these first contacts developed. She evaluated the way in which the HVs were conducted when meeting the pregnant women, relating these services to the broader process of monitoring in the HRPC. The following report illustrates the nurse's perception of possibly having been invasive when offering health care in the pregnant woman's private environment.

> *I remember that G2 accepted the invitation promptly and with enthusiasm. Now, at the first meeting, she was reserved and somewhat apprehensive. I believe it was due to the way I initially approached her: I proposed, "Tell me about your life and pregnancy." I think I was invasive in this proposal. (Field note18)*

Even in the initial encounters, the information shared by the woman about her situation represented challenges and raised questions about how the nurse could offer the necessary support. These elements directly influenced the construction of a relational engagement.

> *P13 revealed to me that she was a doctoral student, and I immediately thought, "What could she possibly need?" I thought I was dealing with someone who did not need informational support. What motivated her to accept?* (Field note 6)

On the part of the nurses, this phase brought about a movement of planning care and a desire to get involved with the woman, especially when there were demonstrations of gratitude, enthusiasm, and recognition on the part of the pregnant woman, valuing the opportunity to have a professional nearby.

> *When I presented the work to G6, it was clear to see her enthusiasm. As a result, I also became enthusiastic and excited* [...]. *She was one of the first pregnant women who was offering home visits, and her enthusiasm gave me a certain sense of hope* [...]. (Field note 18)

In the recorded reports, it is evident that the nurse developed an understanding of women's willingness to receive visits and of the experiences that ranged from positive feelings to frustrations related to pregnancy. Thus, even though some pregnant women showed reservations about establishing a therapeutic relationship with the visitor, the nurse described these meetings as genuine moments of exchange between people interested in building a bond.

> *After a few unsuccessful attempts, P17 accepted the first visit.* [...] *Right at that first meeting, she acknowledged the need for rest, but she expressed sadness, because she was an active person who likes to work, go out and be in contact with nature. At that moment, I reflected on living this pregnancy far from what P17 had idealized for herself, almost expressing frustration and guilt about that condition.* [...] *it seemed to me that the difficulty in following the prescribed therapeutic regimen made her consider accepting the HV. She presented herself in a direct and frank way about her limits and suffering, this brought me closer to her.* (Field note 23)

Emerging identities

Throughout the HVs, it was observed that this phase does not follow a pre-established order, meaning it is not possible to predict how many meetings will be necessary for it to occur. However, this phase begins when there is an openness by both the nurse and the pregnant woman, to be truly present with each other.

In this first meeting with P1, I felt her desire and openness to be with me, and the same happened to me; listening to her story gave meaning for being with her. (Field note 25)

The reports indicate that, when adjusting the relationship, the nurse and the pregnant woman seek to expand their mutual knowledge. The relationship develops gradually, with both demonstrating openness and making efforts to reveal themselves and understand how they can support each other. As the nurse understands the determinants of the needs presented by the pregnant woman, she reflects on how to offer support and what information she still needs to obtain. In this phase, both experiences have relational attributes that indicate interest, effort and trust in the partnership, which may manifest themselves in the first encounter or take a few encounters to materialize.

Anguish, fears, and concern about the possibility of another miscarriage were presented by P2, along with criticism from professionals regarding the pregnancy, making it clear that she feels inadequate and lonely, which has led her to successive suicide attempts. P2's emotional suffering affected me and mobilized me to find ways to support this woman. I leave this HV feeling moved and reflective, issues of psychological suffering are difficult for me, and I have limited skills in this area. On the other hand, I felt that P2 trusted me and told me details of very intimate things. (Field note 43)

We sat on the couch [...] *I asked and encouraged her to talk about her life. P12 began telling me about her abusive relationships, the situations of violence she had experienced, family conflicts, obstetric violence* [...]. *I remember feeling extremely touched in that first encounter.* [...] *I was careful to listen, to understand her feelings and not to intervene in these issues, but I will do so as we build our relationship. I felt a sense of well-being in her presence, a desire to speak openly about herself.* (Field note 35)

The emerging identities of the pregnant women were related to different ways of constituting themselves as subjects in the world, to previous experiences with other professionals and to the anguish caused by their health conditions during pregnancy. They expressed fear and concern about the possibility of abortion, as well as describing sadness, loneliness and a history of suicide attempts. For the nurse, sharing these painful and intimate feelings was perceived as a request for help. During the HVs, the nurse assumed the commitment to build a therapeutic relationship, and the pregnant woman, in turn, responded by agreeing and engaging in the next encounters.

Empathy

In this phase, mutual receptivity is achieved, and relational efforts aim at an increasingly deeper understanding, with the goal of defining the horizon of the relationship. It was clear that the nurse was led to broaden her understanding of social, economic, emotional and rights issues that permeate the lives of pregnant women. The sharing of these situations and sufferings marked the third phase of the relationship.

Another aspect highlighted in this phase was the lack of investment by some HRPC professionals in building a genuine relationship, often performing protocols mechanically and without commitment. As the one-to-one relationship strengthened, both the nurse and the pregnant woman recognized the value of a committed presence, resulting from this investment in the relationship, which motivated them to invest even more in the interactions provided by the HVs.

When P4 told me about a disrespectful appointment, I became very reflective, thinking about how much women need information and autonomy to avoid being subjected to disrespectful treatment. HVs and prenatal care as a whole play this role, and as a visiting nurse, I feel responsible for this care. (Field note 11)

When P17 told me about the situations of excessive touching, I was reminded of the term "vagina school". It is such a cruel and close reality that I feel responsible for ensuring P17 fights for a different experience [...]. (Field note 48)

Knowing that she was asked about her weight because the scales were broken, and that the

appointment was limited to measuring uterine height, listening to fetal heartbeats and checking blood pressure bothered me a lot. Thinking that she waits for 1 hour, that it takes almost the same amount of time to get to the appointment and in a few minutes (about 10) the appointment is already over is revolting. Even more so with the description that 'they barely look you in the eye'. (Field note 27)

In general, there was a lack of relational bonding in the HRPC, something that became increasingly evident as the visits progressed. P11, for example, a more reserved woman, who often avoided eye contact, revealed her loneliness and highlighted the feeling of freedom with the presence of a professional in her home. When questioned and listened to, she became more aware of her own pregnancy situation. The nurse recognized this response and adopted a collaborative approach, wanting to share this sense of involvement and empowerment, while P11 valued this support.

The cases in which empathy was established included situations of obstetric violence and other vulnerabilities, which resulted in a sense of responsibility on the part of the nurse, expressed in the desire to support change and promote women's empowerment.

Sympathy

At this phase, there was a growing process of mutual sharing, intensifying the relationship dance. The nurse was moved by the pregnant woman's experience, making a continuous effort to contribute to her care journey. Trust, availability and support were consolidated, so that the therapeutic goals of the relationship became increasingly concrete. This mobilized and expanded the partnership to achieve them, with the pregnant women taking ownership of the available resources and exercising increasing autonomy.

Each relationship was shaped by the particularities faced by each pregnant woman. For example, with P1, who was experiencing fetal malformation, the focus was on motherhood and establishing the bond with the baby, seeking meaning for the pregnancy and the relationship with the child. With P3, a pregnant woman from a rural area, the focus was on the Health Care Network (HCN), especially on the right to access and the support of her needs, which were being denied by the network.

In this phase, the singularity of each need became the center of care. Despite being classified as high-risk pregnant women, their demands were unique and not always directly related to the reason for their risk classification. It was the process of one-to-one relationships that allowed these singularities to be accessed and meaningful care to be developed for each woman.

P14 was interested in non-pharmacological pain relief methods. In previous visits, without her knowledge, she had mentioned several times how much massages contributed to relaxation during labor in her previous experience. During this HV, I took several photos of pregnant women using non-pharmacological methods and showed them to her [...]. *We also talked about breastfeeding, its challenges, weaning, and baby care in the postpartum period.* (Field note 41)

Since the woman is the one who demands care, the nurse adjusted her actions according to these needs, even increasing the "dose" of HVs, as occurred with P8, P9, and P15, who began receiving weekly visits.

Another milestone in this phase was the recognition that some needs went beyond the nurse's scope, requiring the involvement of other professionals. For P7, occupational therapy intervention was necessary; for P2, support from a psychologist was requested.

[...] *when I suggested the visit of an occupational therapy student, P7 did not fully understand what it was about* [...] *but today, after the student's visit, I realized how unique P7 felt. She told the student about her behaviors, invited her to come more often, accepted her presence and talked about how she used to spend her time. I realize that we are immersed in the fourth phase.* (Field note 22)

Today the visit was led by the psychologist [...] *She remained in care for over an hour with P2. The pregnant woman was offered the option of continuing with therapy in a specialized service. The psychologist and I discussed the case and reflected on the importance and potential of interactions*

that restore the joy and positive experience of this mother-baby relationship. In a way, I felt hopeful, with a sense that I was on the right path and that P2 was embarking on that path, with receptiveness. (Field note 6)

Rapport

Not all pregnant women reached this stage; out of the 17 women monitored, only 14 reached this stage. The main characteristic that marked the achievement of this stage was the increasing involvement of pregnant women in decision-making regarding prenatal care and the type of care they wanted to receive during childbirth, demonstrating greater autonomy.

When P1 was about to undergo surgery, she showed full knowledge about her daughter's malformation and all the factors involved. P2 chose the desired delivery method and successfully carried it out. P3, in her continuous search for support, experienced a transformation in prenatal care in the municipality, when trust and bonding were finally established. P4 became calmer and more aware in using and recognizing the support network for her oldest child. P5 noticed the changes in her body and recognized the beginning of labor. Accompanied by her husband, she gave birth without unwanted interventions, actively exercising her right to privacy. In the case of P6, during an unscheduled hospitalization, she requested the presence of the visiting nurse, who stayed with her until her partner arrived. When her husband arrived, the nurse realized that they could both continue without relying on her presence.

At that moment, what she wanted most was to have a companion, and I was that person. If I hadn't been there that day, she wouldn't have no one. She would have been hospitalized alone and would go through her anguish alone. [...] *We were there in tune, talking, thinking about the next steps.* (Field note 50)

With P8, the development of her parenting was built over time. On the day her child was born, P11 was accompanied by a close friend and underwent her tubal ligation, a situation similar to that of P12, P13, P15, P16 and P17.

P16's sister sent a message informing her that she had taken her to the maternity ward and that she was accompanying her. Interestingly, she told me to stay calm, as P16 had passed on information about the importance and role of the companion during this phase, and that she was already doing it. (Field note 46)

DISCUSSION

The analysis of the phases of the one-to-one relationship in the context of HVs reveals a process of mutual relational adjustment, guided by the meaning and objectives of the relationship. Achieving a therapeutic interaction creates a relational environment in which the woman can present herself and express her specific needs to the nurse. This process affects the professional, encouraging her to make conscious efforts to be present with the pregnant woman and identify unique care that makes sense in the shared context. This not only creates and maintains the relationship, but also leads the woman, in rapport, to assume a more autonomous stance, seeking the nurse's presence only when truly necessary.

In the two initial phases of the one-to-one relationship, there are movements of recognition between those involved. On the one hand, high-risk pregnant women present aspects of themselves and observe how the professional behaves towards them. On the other hand, the nurse receives and internalizes this information, reflecting on it considering her previous knowledge, including social labels. The results indicate that maintaining availability and openness on both sides is essential to advancing the interaction. During the HVs, signs emerge about the functioning and values of each party, which are shared and incorporated into the willingness and availability to maintain the relationship. Additionally, trust, commitment and mutuality are outlined and strengthen the bond, leading the relationship to the empathy phase.

High-risk pregnant women are confronted with information that generates concerns, suffering, anguish, fear, loss and grief[16]. In this context, the nurse's understanding stance is essential to access the nuances of these experiences and effectively respond to their needs. A person-centered approach is essential, as the

relationship transcends the passivity of being merely a patient or a nurse in a technical act, revealing the human dimensions involved[8,15] and, from this, new possibilities emerge.

The results also highlight that, in the initial phase, the woman does not clearly understand what she can expect from the visiting nurse, just as the nurse also launches into projections that may or may not materialize. However, it is up to the nurse to make choices about how to behave and position herself in the relationship with the woman, who, in turn, responds to these interactions by making choices about how to engage in the relationship.

In the empathy and sympathy phases, the relational pair has already defined the limits and horizons of the relationship, sharing information aimed at satisfying the needs around which they have committed. In this dance, care involves a relationship that is open to surrender and respect for the particularities of the other, as proposed by the theory underlying this study[13], respecting technical effectiveness, but without placing it at the center[2,3].

Support needs emerge as the relationship develops. The home visits conducted in this study indicated that the main demands included the guarantee of rights in the pregnancy-puerperal cycle, informational support and access to healthcare services. However, it is known that informational support in the context of high-risk pregnancy is largely insufficient, as it is often transmitted in a language that is difficult for women to understand[17,18,19] and is focused on a biomedical approach, prioritizing fetal well-being and obstetric risk-related issues[20].

International studies indicate that nurses still provide prenatal care far from the individual experiences of each pregnant woman, missing opportunities to offer health education and support in complex situations, as well as to facilitate a more equitable use of healthcare resources[21,22].

Denial of access to rights and healthcare services was a constant issue in the results, marked by reductionist care and prescriptive and punitive behaviors of professionals in the context of the HRPC. These results corroborate the idea that risks in other areas of pregnant women's lives are disregarded or minimized in healthcare appointments[20]. Home visits, structured in a one-to-one relationship, counterbalanced these aspects, ensuring rights and facilitating access to services.

The findings of this study allow us to affirm that the practical success of care creates an conducive environment to the disclosure of unique needs and to an equally unique welcoming process, centered on the collaborative partnership between professional and pregnant woman, within the horizon of the woman's autonomy. When prenatal care is constructed based on one-to-one relationship in the context of home visits, the processes derived from this relationship are essential for women to assume and develop their health and life projects. The interaction between nurses and pregnant women is related to the satisfaction and effectiveness of nursing care on the part of the woman[23], and is recognized as relevant for the HRPC[24].

Developing a one-to-one relationship at home is a determining factor that favors the sharing of lives, sufferings, and particularities, especially in the context of a high-risk pregnancy[25]. This study confirms that the home setting and the HV are differential, powerful and care-promoting elements[25], facilitating the one-to-one relationship, as long as a critical stance is maintained toward the hegemonic health model that focuses only on risk[26]. The HV requires a sensitive and respectful professional position to what is accessed in this unique environment, which powerfully reveals the particularities of the person and their life[27].

When professionals allow themselves to be involved and guided by the needs of each woman, the person who requires their care, they are affected by these interactions, which drives and mobilizes them toward the relationship. This involvement gives meaning and purpose to the act of caring, allowing professionals to attribute meaning based on the experience of illness and/or suffering of those who need their support.

Healthcare is relational, and its achievement depends on commitment and investment in interactions. Achieving therapeutic interaction promotes growth and transformation throughout the process, enabling the realistic identification of problems and the establishment of actions in a shared and collaborative manner, considering the circumstances of patients' lives. In this way, the possibility of alignment with two central principles of healthcare in the Brazilian health system is expanded: comprehensiveness and equity.

It is expected that professionals directly involved in the care of high-risk pregnant women will be impacted by the discussions presented here and, more than that, promote and practice new forms of relationship in care. Building genuine relationships implies committing to fulfilling rights and duties, to the citizenship of these women and their families, with the aim of mobilizing care that enhances practical success.

As an advancement for nursing and health, the need to restore the centrality of the relationship for care and to renew practices through one-to-one relationships stands out. The follow-up of high-risk pregnant women involves cycles of vulnerability, history, access, and the right to healthcare. However, only through relationships can realistic changes be projected. This study indicates that valuing relationships is crucial to achieving the desired outcomes in HRPC.

One limitation of the study was that, although the HVs were conducted by two nurses, it was not always possible for both to be present at the same time in pregnant women's homes. This issue was minimized by the similarity of values, concepts, professional experience and academic training among the professionals, with an emphasis on the person- and family-centered approach, and on the appreciation of the relationship for health and nursing care.

Additionally, there were limitations in meeting and resolving women's healthcare needs, since the complexity of these demands required the involvement of PHC services, which did not occur during the follow-up of the 17 pregnant women. Even with the focus on one-to-one relationships, the lack of available services in the healthcare network created gaps in care.

FINAL CONSIDERATIONS

The one-to-one relationship in the context of home visits by nurses to high-risk pregnant women was permeated by the establishment of bonds and the deepening of the therapeutic relationship between the nurse and the women. Throughout the study, individual needs were identified, as well as a process of reflection by the nurse on her role in the follow-up. The women, in turn, achieved greater autonomy at the end of the study period. Although it is an abstract concept, the one-to-one relationship in the HVs resulted in practical successes for both the participants and the nurses, because it was possible to understand the values of the intersubjective relationship assumed in the experience of the visit.

Placing the relationship as a central element of care makes interactions more authentic, opening space for experiences that touch on human existence. This allows for the subjective production of care, integrating the relational process with technical action, legitimizing different care technologies and, consequently, addressing the diverse and complex needs of high-risk motherhood without obscurantism.

By publishing the results of this research, the discussion on the importance of recognizing relationships as a central practice in care and the need to train healthcare professionals for this purpose is broadened. In nursing, Travelbee's theory reinforces the centrality of relationships in care, highlighting the importance of policies and programs that consider care in an expanded way, promoting welcoming, dialogue, and bonding in healthcare practices.

It is essential to emphasize the nurse-patient relationship, investing in all spaces dedicated to care, as this is a valuable element for both practice and professional training. Therefore, it is recommended to consider relationships as an essential dimension of care, which should be the guiding axis of care. Otherwise, the lack of this consideration weakens all other technologies, as care is configured within the relationship, an essential concept for nurses, allowing reflection and change in practice.

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Data and material availability

Access to the dataset can be obtained upon request to the corresponding author.

Authorship contribution

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